UNITED STATES DISTRICT COURT
DISTRICT OF MINNESOTA

James and Lorie Jensen, as parents, Guardians and next friends of Bradley J. Jensen, *et al.,*

Plaintiffs

Minnesota Department of Human Services, an agency of the State of Minnesota, *et al.,*

Defendants

Civil No. 09-1775 (DWF/FLN)

Independent Consultant and Monitor

SECOND REPORT TO THE COURT: Procedural Requirements on Restraint

Evaluation Criteria 16-20 and 22, 23 and 25, 29-38 and 40-42

David Ferleger
Archways Professional Building
413 Johnson Street
Jenkintown, PA 19046
Phone: (215) 887-0123
Fax: (215) 887-0133
david@ferleger.com

Independent Consultant and Monitor

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I. EXECUTIVE SUMMARY

Relevant Evaluation Criteria: 16-20 and 22, 23 and 25, 29-38 and 40-42

Safeguards against misuse of restraints are a key feature of the Settlement Agreement.[1] The protections are both substantive and procedural. Multiple levels of review and response are mandated, including several which may serve a quality assurance "post-event" purpose.

The review is limited to the *procedural* "nuts and bolts" requirements of the restraint form provisions and does not encompass clinical or judgmental questions. No final compliance conclusions are reached, pending adoption of a *Compliance Certification Process,* which is under discussion with the parties.

This review was undertaken for two purposes. First, given the role of restraint in this case, it is appropriate to take an early look at some aspects of compliance with the restraint process. Second, I hope that the findings here assist the parties to reach agreement without the need for judicial intervention the "Third Party Experts" issue; absent agreement, I will make a recommendation to the Court.

1. The monitor concludes that Defendants are generally <u>in compliance</u> with the procedural requirements for the restraint form for the seven restraints since the December 5, 2011 court approval of the Settlement Agreement.[2] Defendants are commended for this compliance. The Emergency Interdisciplinary Team (EIDT) element may benefit from increased attention.

2. Compliance with the requirement for prompt post-restraint consultation with one of five Third Party Experts is disputed by the parties. The list of five experts was never established.

3. The DHS Internal Reviewer process needs improvement. It does not now focus on broad Settlement Reviewer mandate "to assist eliminating the use of manual and mechanical restraints." There is no indication in the records that the Internal Reviewer meets with on-the-scene staff involved in the restraint instances or considers more global facility issues related to his mandated role. Cambridge leadership does not always respond at with a level of attention which meets the

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[1] The safeguards are in the Settlement Agreement's text, and its Attachment A. The reader's familiarity with these documents is assumed.

[2] I also reviewed some other restraint incidents in the June-December 2011 period which includes the months after the parties' filed the Settlement Agreement with the Court.

substance of the Reviewer's recommendations. Also, some reports highlight the need for heightened central office attention to matters raised in the reports.

Two formal requests to the parties conclude this report: a) I urge the parties' to agree on a resolution of the Third Party Expert issue, and b) I urge Defendants to consider improvement of the Internal Reviewer process and communicate their intentions to Plaintiffs, to me and the consultants; the issue will be discussed at the October 24, 2012 parties' meeting.

A draft of this report was provided to the parties September 12, 2012. No comments or objections have been received. The parties are advised that any comments or objections to this report should be filed within 21 days.

II. BACKGROUND

Public reports several years ago of misuse of restraints at METO spurred this litigation. The Settlement Agreement established a $3,000,000 fund for "per restraint/seclusion" payments to METO clients subjected to restraint or seclusion and for fees and costs. The MSHS-Cambridge ("Cambridge") program is the successor to METO, and is housed in some of the same buildings at METO; many of the staff who work at Cambridge worked there when it was METO.

Safeguards against misuse of restraints are a key feature of the Settlement Agreement.[3] Restraints are never to be used as part of a treatment program; they may be used only in a strictly defined "emergency." All mechanical restraints are forbidden except for emergency use of velcro soft cuffs and fabric ankle straps. Manual restraint, within certain bounds, is permitted in an emergency. Use of medication for behavior control or behavior modification ("chemical restraint") is forbidden, as is restraint for the convenience of staff.[4] The nature and duration of restraint use is restricted.

In addition to substantive limitations (which are not addressed in this repor), extensive procedural protections are in place. Multiple levels of review and response are mandated, including several which may serve a quality assurance "post-event" purpose.

A detailed record (Form 31032[5] or "Restraint Report") must be completed during the shift by several levels of on-site staff for each use of emergency restraint. Following each restraint:

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[3] The safeguards are in the Settlement Agreement's text, and its Attachment A. The reader's familiarity with these documents is assumed.

[4] Seclusion and time out are also forbidden.

[5] The Settlement Agreement's Attachment A calls this Form 31032. The form is now called DHS-3652.

a. Within 30 minutes, Cambridge staff must call one of a panel of at least five experts ("Third Party Experts") from a list pre-approved by Plaintiffs and Defendants. Absent such a list, the DHS Medical Officer is called.

b. Within 30 minutes, the DHS medical officer on duty is called.

c. Within 24 hours or one business day, the DHS Internal Reviewer receives a copy of the Form 31032.

d. Within 14 calendar days, members of the Emergency Inter-disciplinary Team ("EIDT") must confer to discuss the incident, how it was handled, and possible recommendations to the Inter-disciplinary Team for adjustments in the client's plan.

e. Within 5 working days of the EIDT review, the Designated Coordinator documents any EIDT recommendations on METO Form #31025 (now called DHS 3653), forwarding it for filing in the client's permanent record, and to the Behavior Management Review Committee.

f. When restraint of a particular client occurs more than twice in 30 days, it must be reviewed by the EIDT, METO Director, facility Clinical Supervisor or designee, and the DHS Internal Reviewer to consider modifications to the client's treatment plan.

g. Whenever additional staff are needed for intensive negotiations or use of restraint, a Critical Action – Review of Experience (CARE) meeting is held.

In addition, an Internal Reviewer, is to to "monitor[] the Facility's use of restraints."[6] In addition to receiving individual restraint reports, "The internal reviewer shall consult with staff at the Facility in order to assist eliminating the use of manual and mechanical restraints."[7]

Encompassing the above requirements, this report is an inquiry into compliance regarding Evaluation Criteria 16-20 and 22, 23 and 25, 29-38 and 40-42 in Defendants' Status Report.[8] No final compliance conclusions are reached, pending

[6] Settlement Agreement, Sec. VII.A.1.

[7] *Id.* at Sec. VII.A.1. The Settlement also requires an External Reviewer; that safeguard is not addressed in this report.

[8] Evaluation Criterion EC 16-20 and 22 address the Third Party Expert requirements. EC 23 requires that the DHS medical officer on call be contacted

adoption of a Compliance Certification Process, which is under discussion with the parties.

III. PURPOSES OF THIS REPORT

Misuse and excessive use of restraint has been a focus of this litigation. I determined it would be appropriate early in my monitoring role to perform a review and verification of compliance with the Settlement's procedural reporting requirements.

This review is thus limited to the procedural "nuts and bolts" requirements of the Settlement Agreement's restraint form provisions. I did not seek to review and I did not consider at this time such clinical or judgmental questions as the appropriateness of the restraint use or whether less intrusive options were available.[9] Also, I did not seek to determine now whether restraint use was limited to "emergencies" as defined in the Settlement.[10]

IV. METHODOLOGY

I obtained from DHS the Restraint Reports for all incidents since the Court's approval of the Settlement, as well as the Cambridge staff's contemporaneous hand-written "Progress Notes" from the clients' charts for the time period including the restraint.

Seven Restraint Reports, and associated documents, were received and represented to be the record of all restraint use since the December 5, 2011 Court approval of the Settlement.

The Restraint Report is typewritten into a reviewed computerized form. The Progress Notes are a chronological on-the-scene handwritten record of the experience and observations of the nursing and related treatment staff. For one Restraint Report (JR, 6/10/12), a draft was available to compare with the final version.

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within 30 minutes after the emergency restraint began. EC 25 requires that the consultation with the medical officer is documented in the resident's medical record. EC 29-38 include procedural requirements for Form 31032. EC 40-42 are the Internal Reviewer requirements.

[9] I do not draw conclusions here regarding clinical or judgmental issues in the work of the DHS Internal Reviewer, Dr. Richard Amado, or the professional interactions between Dr. Amado and the treatment director, Stuart Hazard. As discussed below, I do consider whether DHS is fulfilling the the Internal Reviewer requirement.

[10] Future compliance reviews will consider such clinical and definitional questions.

I also reviewed the reports of the post-restraint consultation with the Emergency Inter-disciplinary Team ("EIDT Report").[11] This is nearly entirely a "check-off" form with some blanks for entry of a narrative response.

There was no occasion during the time period for Defendants to comply with two requirements: the special review when a client is subject to restraint more than twice in 30 days, and the Critical Care review for unusual situations. Compliance regarding these infrequent events was therefore not reviewed.

V. RESULTS

A. General

One person was restrained twice, one was restrained three times, and two other individuals were restrained one time each. The following table shows Restraint Report dates, duration of restraint, and the time interval between the initial Report and the EIDT Report:

	Restraint Report	Restraint Duration	EIDT Report
BB1	1/29/12	9 minutes	N.A.
BB2	5/10/12	1 minute	N.A.
NK	5/19/12	15 minutes	5/25/12
JR1	5/4/12	3 minutes	5/4/12
JR2	6/10/12	3 minutes	6/13/12
JR3	7/5/12	11 minutes	7/10/12
JS	8/10/12	10 seconds	None

Restraint was utilized in a relatively few instances and, except for one 15 minute restraint, for less than 10 minutes each of the remaining six times. Four of the seven instances were for 3 minutes or less. The missing EIDT was not created until mid-September, after the monitor inquired about its non-existence.

In all cases, restraint was manual. In no case was either of the permitted mechanical restraints used.

It is to be noted that the frequency and the duration of restraint use in this period is significantly less than that during period which precipitated this lawsuit.

[11] This is called Form 30125 in Attachment A and is now called Form DHS-3653.

Adherence to the procedural requirements is shown below:

Requirement	Compliance?	Comment
Restraint Report completed & signed	Yes	100%
Call one of 5 Third Party Experts, within 30 minutes.	No	0%. See discussion below.
Call DHS medical officer within 30 minutes.	Yes	100%. Calls to DHS Medical Director Dr. Radke are documented, generally including case-specific recommendations to staff.
DHS Internal Reviewer notified in 24 hours or 1 business day.	Yes	100%.
EIDT confers to discuss, within 14 days.	Partial	In 4 of the 7 cases, the EIDT report was present and timely, dated the same date or within a few days of the restraint. In 2 of the 7, no EIDT report was done since the client was transferred to another facility. In 1 case, the most recent case (restraint date, JS, 8/10/12), no EIDT report was done until after 9/11/12, when the Monitor inquired about its absence.

B. Third Party Expert

A Third Party Expert is to be consulted by telephone within 30 minutes of an emergency restraint use. DHS pays for this consultation. In no case was the Third Party Expert consulted.

The Settlement Agreement calls for list of experts "pre-approved by Plaintiffs and Defendants."[12] The list of five such experts was never established. Defendants' *Status Report* (September 17, 2012) states, "The Department was not able to secure

[12] Settlement Agreement, Sec. V.E. EC 17.

the services of qualified Third Party Experts," but does not provide documentation of efforts to do so.[13]

In the absence of the "list of five," Defendants utilized the consultation with the DHS Medical Officer.[14] That consultation, it is noted, is separately required in addition to the Third Party Expert review.

Defendants have explained that they attempted to recruit such experts but were unsuccessful, and they are skeptical, for a variety of reasons, that a renewed attempt would be successful. Plaintiffs believe that the Third Party Expert function is important and that the list should be established.[15]

C. Internal Reviewer

The DHS Internal Reviewer provides detailed reports which state that they are based on "review of medical records" and, in most cases, interview with the facility director and/or one or two other staff. Each report addresses only the specific incident, and includes one or more recommendations. The Cambridge treatment director responds in narrative, with a check-off "accepts," "rejects" or "accepts with modifications."

VI. DISCUSSION

A. General.

The monitor concludes that Defendants are generally in compliance with the procedural requirements for the seven restraints in this time period. Defendants are commended for this compliance. This conclusion is apart from the issues of the Third Party Expert and the Internal Reviewer, discussed below.

Pending adoption of a Compliance Certification Process (under discussion with the parties), no recommendation is made at this time regarding conditions for release of these Evaluation Criteria from active judicial oversight.

Although it is unfortunate that one EIDT report was belated, the monitor does not consider that alone to raise a red flag on procedural compliance at this point. However, the apparent failure of Cambridge to note and correct this violation until the EIDT report was requested by the monitor is a concern. Also, the EIDT appears rarely to make recommendations for changes in the client's treatment plan.

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[13] Defendants' *Status Report* at EC 17, p. 16.

[14] Settlement Agreement, Sec. V.F., EC 23-25.

[15] This parties' views described in this paragraph are based on discussion in the September 20, 2012 parties' meeting.

Whether this is appropriate to each situation was not reviewed; it may be useful for Defendants to examine the functioning of the EIDT process.

B. Third Party Expert.

The non-existence of the Third Party Experts needs to be addressed promptly. Whether Defendants may continue to rely on the "fall-back" of DHS Medical Officer review or whether the initial effort to recruit the list was flawed and negated compliance, need not be considered at this time.[16]

That the parties considered this to be an important safeguard is evident from the fact that they agreed that the requirement would extend until *June 30, 2015*, about one and a half years after the December 4, 2013 date for an end to the court's retention of jurisdiction.

The Third Party Expert reviews did not occur at all. There is no list of 5 experts. The parties do not agree on how to proceed. Absent agreement at the October 24, 2012 parties' meeting, the monitor will make a formal recommendation to the Court to resolve this matter.

C. DHS Internal Reviewer

Compliance with the Internal Reviewer requirements is problematic at several levels. Improvement is needed.

The DHS Internal Reviewer under the Settlement "shall consult with staff at the Facility in order to assist eliminating the use of manual and mechanical restraints." This is a broad mandate, and is not limited to case-by-case tasks. The breadth makes sense in the context of the other safeguards. First, staff are to be trained regarding restraint use. When an incident occurs, the Third Party Expert is contacted quickly, along with the DHS medical officer. The EIDT does its work. Then, after some time for reflection, the Internal Reviewer is called upon not simply on the individual case, but to assist the facility to "eliminate" the use of restraints.

Currently, the Internal Reviewer reviews each restraint report and issues a brief report on the case at hand. There is no indication in the records that the Internal Reviewer meets with on-the-scene staff involved in the restraint instances or considers more global facility issues related to his mandated role.

Each report is essentially a limited paper review of a single case.. The review itself, and the MSHS-Cambridge Facility Director responses focus on the individual situation (which is, of course, appropriate) but with little or no attention to the mandated Internal Reviewer role "to assist eliminating the use of manual and mechanical restraints."

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[16] *See* Settlement, Sec. V.E. and EC 16-20 for the requirements.

Importantly, there is no indication in the documentation that the Reviewer's reports are reviewed (or received) by superiors in DHS responsible for overall compliance with the Settlement Agreement.

I do not fault the Internal Reviewer here. It appears that he is taking this case-by-case approach under instructions.

At this point, there is no necessity for me to prescribe how the Internal Reviewer, Cambridge and DHS' central office might improve the system. Among possibilities, for example, are that the Internal Reviewer might:

- Meet with the staff on the living unit who witnessed and responded to the situation precipitating the restraint, and provide feedback on what occurred.
- Provide consultation to supervisors at Cambridge on the incident and on the individuals' treatment plans.
- Address in his reports global issues (environment, client treatment plans, staffing and supervision, and the like, so that the mandate might be fulfilled.
- Interact with the facility and the DHS central office on actions which might be taken to assist in the elimination of restraints.

The reports suggest a need for heightened central office supervision over Cambridge:

• BB's situation revealed a negative by-product of a major change in Cambridge's admission process after the "change-over" to a "new treatment model." There is no indication that the elimination of intake meetings was upon the "new treatment model" was approved outside of Cambridge.

• KK's continued placement at Cambridge was unnecessary, as Cambridge stated. He was awaiting a delayed establishment of a new home in the community.

In one case (BB, 1/29/12 restraint), Cambridge stated that "upon the change-over to our new treatment model," intake meetings on the day of admission were eliminated and replaced with "ten day meetings" for "initial planning." After the Internal Reviewer noted that BB's known medical issues may not have been timely addressed, Cambridge agreed that it "had not had an adequate picture" of BB's needs, and was "re-instituting" day of admission intakes where possible.

KK was restrained 5/19/12 after his complaints about a housemate who cleaned the bathroom floor escalated. The Internal Reviewer noted that his "behavior can be managed in a less restrictive setting with properly trained staff" and that KK is "close to moving out." He recommended creation of a discharge schedule. Cambridge responded that the MSOCS' home is "not yet open" and that any schedule "is not known to us or under our control." No remedial effort was undertaken by Cambridge.

There is no indication that Cambridge or the Internal Reviewer used the occasion of KK's restraint as a prompt for others in DHS to accelerate the placement or to work with KK to ease any anxiety around the delay.

VII. REQUESTS TO THE PARTIES

The monitor has no requests to the parties regarding compliance with the procedural elements of the restraint reports discussed above. As noted, it may be beneficial to address the EIDT process.

Request to the Parties No. 7[17]
Third Party Experts.

The monitor requests that, if the parties confer before the October 24, 2012 parties' meeting (as they agreed to do at the September 20, 2012 parties' meeting) and cannot resolve this matter, they submit their respective views to the monitor in writing on or before October 19, 2012.

The monitor shall thereafter report to the Court his recommendations on compliance with Evaluation Criteria 16 and 17.

Request to the Parties No. 7
DHS Internal Reviewer.

The monitor requests DHS to consider revising the process and nature of the Internal Reviewer activity, and his interaction with the facility staff and administration, and action-oriented review of the Reviewer reports within DHS central office. Also, the monitor requests DHS to consider expanding the paper review to include discussion and consultation with on-the-scene staff and to encompass global issues related to the Settlement-defined purpose of the review. That purpose is not solely on the individual case, but is "in order to assist eliminating the use of manual and mechanical restraints."

DHS is requested to respond to this request in writing by October 17, 2012, so that it may be discussed at the October 24 parties' meeting.

[17] This numbering of this "request to the parties" follows the monitor's practice of identifying such requests by number to facilitate tracking of the parties' responses. There were six prior formal requests conveyed to the parties by letter.

The monitor expresses his appreciation to the parties for their consideration of this report.

Respectfully Submitted,

/s/ David Ferleger
David Ferleger
Archways Professional Building
413 Johnson Street
Jenkintown, PA 19046
Phone: (215) 887-0123
Fax: (610) 672-9680
david@ferleger.com

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